EXHIBIT 10

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	:	MDL No. 2804
	:	Case No. 17-md-2804
APPLIES TO ALL CASES	:	Hon. Dan A. Polster

HIGHLY CONFIDENTIAL

SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

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JANUARY 22, 2019

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VIDEOTAPED DEPOSITION OF FRED BENCIVENGO, taken pursuant to notice, was held at Marcus & Shapira, One Oxford Center, 35th Floor, Pittsburgh, Pennsylvania 15219, by and before Ann Medis, Registered Professional Reporter and Notary Public in and for the Commonwealth of Pennsylvania, on Tuesday, January 22, 2019, commencing at 2:08 p.m.

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they may not be valid or they'd be at risk of diversion?

MR. KOBRIN: Object to form.

THE WITNESS: Yes.

BY MR. HUDSON:

Q. How many times would you say that happened?

A. Again, with the new law being capped, I couldn't even speculate. I know that it happens.

Q. Do you remember any of the details around any times where pharmacists ever raised concerns with you?

A. The majority of the time, if the doctor has a bad name in the area. So they wanted to know if they could not fill any prescriptions from Dr. Bencivengo. We don't -- we support them a hundred percent on their decision to fill or not fill, but we don't support just blankly saying we're not filling any prescriptions from a doctor.

We have a process in place. You do your due diligence. You make a decision that way. If part of the due diligence says this guy doesn't need a script, he's a bad doctor, then send them on the way. We don't have any list of doctors that we don't fill for.

Q. In your territory in Ohio, from time to time were there doctors identified by pharmacists that they believe to be bad doctors?

A. Yes.

Q. Did you or anyone else at Giant Eagle keep a log or a record of bad doctors in Ohio that a prescription being written by them at least raised a red flag of concern?

A. Again, no official log. I've walked into many stores and saw something hand scribbled on a bulletin board, be careful of these three doctors; not do not fill, just but be careful.

Q. Was that more of an individual store to individual store?

A. An FYI. If I'm coming in as a floater that day, this is what I should look for.

Q. Was there any sort of log or -- I'm trying to think of a good -- report, any way that Giant Eagle is memorializing diversion risks at the pharmacy level in terms of bad doctors or anything else that would cause there to be a concern about the diversion of controlled substances?

MR. KOBRIN: Object to form. What do you mean by bad doctors?

using the term suspicious orders and flagged orders concurrently or interchangeably.

MR. HUDSON: Because they are.

MR. KOBRIN: I don't think they are to the witness. I think you're causing confusion with him regarding flagged and suspicious orders.

THE WITNESS: Okay. That makes sense.

MR. HUDSON: I'll let you clear that up.

MR. KOBRIN: Well, I'm flagging that issue for you.

Should we take a break?

MR. HUDSON: Yeah, that's fine. Take a quick break.

THE VIDEOGRAPHER: We are going off the record. The time is 3:11 p.m.

(Recess from 3:11 p.m. to 3:42 p.m.)

THE VIDEOGRAPHER: We're going back on the record. The time is 3:42 p.m.

BY MR. HUDSON:

Q. Welcome back, Mr. Bencivengo. Before the break, we were talking about pharmacists and potential red flags for diversion, and you had made reference to OARRS reports and CBTs, and that kind of took us down this road.

So I want to go back to my original question

which was: For Giant Eagle pharmacists, was there any sort of uniform criteria that existed to apply to try to determine whether to fill a prescription or not?

MR. KOBRIN: Object to form.

THE WITNESS: We have document control dispensing. In that document it lists the red flags, what to look for to do the due diligence and to make that decision.

BY MR. HUDSON:

Q. As you sit here today, do you have a recollection of what those red flags are?

MR. KOBRIN: Object to form. Do you want to show him the document?

MR. HUDSON: I don't have it.

THE WITNESS: I mean, I can't name every single one of them, but obviously the age, the distance, the distance they drive, the distance from the doctor to the pharmacy and the distance where they live and to the pharmacy. If they mention the drugs by the street names, Percs, Vics. Any kind of combination product, the trinities, the pain reliever, the muscle relaxer, those are usually a sign that calls might need to be made.

BY MR. HUDSON:

Q. And in Ohio in your 12 years there, in your experience, were there patients coming into pharmacies that were trying to get drugs that weren't for medically necessary purposes?

MR. KOBRIN: Object to form.

THE WITNESS: Yes.

BY MR. HUDSON:

Q. And how did you come to that opinion?

A. As a practicing pharmacist or as a person in my role right now?

Q. Yeah, just as a whole, in other words, really through those 12 years in your role as a PDL.

A. By doing the due diligence we needed to do to fill those prescriptions, by viewing the red flags, and then once it was determined, that's when it was determined this wasn't necessary.

Q. Did you have enough interaction with pharmacists and just the communities of Ohio to get a sense of whether or not opioid diversion or opioid abuse was a problem in the communities where your territory existed?

MR. KOBRIN: Object to form.

THE WITNESS: Enough with the

those doctors as a matter of policy or how you kept track of those doctors or which scripts were refused. Do you recall that?

A. Yes.

Q. If a doctor was identified as a licensed doctor who was causing concern for pharmacists, what steps would your pharmacists take in your pharmacies?

A. Well, I think, for the most part, you go in the stores and see a doctor's name on a cork board, taped to a monitor so that anybody that comes in there is aware that we're not not filling all scripts from this doctor, but we're going to scrutinize and drag that prescription through the mud as much as possible to make sure it's for a legitimate purpose.

A guy comes in. It's after the hours. We can't get ahold of the doctor. It's not getting filled. What we normally do after that is send an email out at times or call the local stores and say we just turned this guy away and this is the reason. It goes out to the stores. I've had times or I've heard of times where other stores, CVS, has called us. If we have a store across the street, a competitor, we may call the competitor

and say, you know what, we just sent this guy there with a script. He took it back. He may be coming over to you now and this is why. But they're in the same area, so they have all the same docs anyway.

Q. So even if the person with a script from the doctor who's kind of identified by the pharmacy, even if that particular person bringing that particular script in didn't raise any red flags, you would still scrutinize that script?

MR. HUDSON: Object to the form.

BY MR. KOBRIN:

Q. Would you still scrutinize the script even if the patient bringing in the script from a doctor who had caused some concern for your pharmacists? Would you still scrutinize it even if there were no red flags?

MR. HUDSON: Object to the form.

THE WITNESS: If it's from that doctor, is that what you're asking?

BY MR. KOBRIN:

Q. Yes.

A. We would scrutinize it.

Q. How would you scrutinize it?

A. Reading the OARRS report, calling for

the diagnosis whether he wants to give it to us or not, and only filling it during his business hours. And if you can't get ahold of him to verify that he even wrote the script, then we would either give it back or -- it all depends.

There's two options. We'll call the doctor in the morning for you. Come back and get it. Or the guy might say, no, just give it to me. Then we would try to call CVS or send an email out and warn we just gave the script back. This is why.

Q. You said that anyone who comes in can see the name on the cork board. By that do you mean anyone, customers?

A. No. It's back in the pharmacy facing us.

Q. So everyone at the store would know to scrutinize this doctor's script?

A. The pharmacists, yes.

Q. We talked earlier in relation to your testimony about doctors who were licensed but still caused some concern to your pharmacists about rejecting scripts. Do you recall that?

A. Yes.

Q. And I know you said that you were -- I believe your testimony was that you were a hundred

percent certain that it happened and the scripts were rejected, but you couldn't give an exact description of when that happened. Do you recall that?

A. Yes.

Q. Is that accurate?

A. It's an inexact number. I would say that it happens weekly for the main reason, which hasn't changed, is they always need it two or three days early, early, early. So you start billing. It comes back too soon. You look at the OARRS report. You see the last time it was filled, and we don't fill it.

Q. So it did happen regularly, we'll say, that scripts were rejected at the pharmacy that you oversaw?

A. Correct.

MR. HUDSON: Object to the form.

BY MR. KOBRIN:

Q. Did it happen regularly?

A. Yes.

Q. You testified a little bit about thresholds and the thresholds, whether they be from McKesson or Anda or HBC. Do you remember that?

Q. And you mentioned LP. What is LP?

A. Loss prevention.

Q. And they're the people who kind of help you research all these issues at the next level?

A. Yes.

Q. I think we're all set.

MR. KOBRIN: Pass the witness.

RE-EXAMINATION

BY MR. HUDSON:

Q. In terms of scripts rejected, you testified that it happens weekly. Is that just your sense from, as you sit here today, the best of your recollection?

A. It's my sense of just from me being in the store from the time period we're talking, to conversations about compliance with my team members, what are some of the reasons we're turning away scripts.

Q. Is there any reason why Giant Eagle couldn't have kept a scripts rejected log or written down on the computer system or somewhere each instance where a prescription was rejected and the reason it was rejected?

MR. KOBRIN: Object to the form.

THE WITNESS: There would be no reason

to keep a log like that. You're determining whether you're going to fill something or not fill it. You make the determination. You can put into the computer refilled too soon or whatnot. If you take the script back, there's no record in the computer of the script.

BY MR. HUDSON:

Q. Right. All I'm saying is in the computer system or somewhere could Giant Eagle keep a log of scripts that were rejected due to suspicion of diversion?

MR. KOBRIN: Object to form.

THE WITNESS: No, because some of those don't even get into our system. If you bring a piece of paper to me and I do everything that we spoke about here for the last -- since 1:00 or 2:00, that prescription might not get dropped through our system and even get in the system. So there's no record of the prescription even there. We just hand it back to you. You take it away.

BY MR. HUDSON:

Q. Right. I guess what I'm saying is, is there any reason why Giant Eagle couldn't keep a log of some kind or a repository, like you take the script and you go, this thing, this just

doesn't look right to me. I'm not filling this script. In my professional judgment, this isn't legitimate. Here's the name and what they were trying to fill and then the reason for rejecting it is because this doesn't look legitimate to me and I think it's a possible risk of diversion.

Is there any reason why Giant Eagle pharmacists couldn't as a matter of practice have kept a log of prescriptions where they decided not to fill them?

MR. KOBRIN: Object to form.

THE WITNESS: I don't know. I don't know why we would ever look at that log. I do not know what purpose it would serve. We've already determined we're not filling it.

BY MR. HUDSON:

Q. Well, one purpose would just be to have some sense, as we sit here today, of how many prescriptions there were that were at risk of diversion that were rejected; right?

MR. KOBRIN: Object to form.

THE WITNESS: It would help you here today, yes. It would help what you're trying to go after. It would help. But it wouldn't give us anything.

BY MR. HUDSON:

Q. Well, it would help Giant Eagle, too, because if you said that weekly -- it's your sense that weekly pharmacists within your territory are rejecting filling prescriptions, you could go to that rejected prescription log and look at it. And then we'd be able to say, yeah, Pennsylvania is right. Look down the log. Every week there's a pharmacist that's not filling a prescription.

MR. KOBRIN: Object to form. Argumentative.

THE WITNESS: That was my response. It would help your case, but it wouldn't do anything for me. I would never have to see that. They didn't fill the script. They did what they're supposed to do.

BY MR. HUDSON:

Q. Were you ever concerned or to your knowledge was anyone at Giant Eagle ever concerned about diversion of opioids?

A. All of Giant Eagle is concerned. Any pharmacist, any pharmacy is concerned about diversion of opioids.

Q. Would keeping records and trying to track the reasons why prescriptions are not filled

potentially serve a role to Giant Eagle in becoming better at preventing diversion?

MR. KOBRIN: Object to form.

THE WITNESS: I don't believe it would.

BY MR. HUDSON:

Q. Similarly, on Exhibits 11 and 12, when you look at the line items, there's well over a hundred, probably a couple hundred line items from pharmacies in your territory of inventory discrepancies just for these two months, right --

MR. KOBRIN: Object to form.

BY MR. HUDSON:

Q. -- that we've looked at?

A. We looked at about 20 discrepancies. The rest of the report are all resolved issues.

Q. Well, let's look at back then at Exhibit 11. We looked at 20 discrepancies where the reason for it was unknown; right?

MR. KOBRIN: Object to form. If we're going to say 20, we should know what we're talking about here.

BY MR. HUDSON:

Q. We went through. The record is what is. We went through them; right? Whatever it is it is.